TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Orthropaedic Surgical

Respondent Name
Facility Insurance Corp

MFDR Tracking Number
M4-13-2431-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 24, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We followed the proper protocol in this patients care by obtaining authorization."

Amount in Dispute: $183.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed $6192.10. Carrier has issued reimbursement in the amount of $91.45. Charges billed under CPT codes 64999 and 76000 were denied because the provided services were ineligible for reimbursement as preauthorization was not secured pursuant to 28 TAC 134.600 prior to the rendition of the services. Carrier had issued preauthorization only for CPT codes 64483 and 64484. Carrier maintains that reimbursement is not owed for the unauthorized services."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2013	64999	$183.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets outs out the guidelines for prospective and concurrent review of health care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 851-001 – Payment denied/reduced for exceeded precertification/authorization

- 901 – Reconsideration no additional payment. Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The service in dispute is for outpatient surgical services. The insurance carrier denied disputed services with claim adjustment reason code 851-001 – "Payment denied/reduced for exceeded precertification/authorization." 28 Texas Administrative Code §134.600(p) states,

   Non-emergency health care requiring preauthorization includes;

   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted information finds that:

   - Submitted code(64999) which is described as, "Unlisted procedure, nervous system"
   - UniMed Direct gave prior approval for "Bilateral L5 and S1 hardware injection test"
   - Authorized code (64483) which is described as, "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level"
   - Authorized code (64484) which is described as, "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)"

   The insurance carrier's denial reason is supported as the submitted code in dispute was not included as part of the prior authorization request. Additional reimbursement cannot be recommended.

2. Pursuant to requirements of Rule 134.600(p)(2) the service in dispute was not prior authorized therefore, payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.